DEPARTMENT OF STATE HEALTH SERVICES
Radiation Safety Licensing Branch
Mammography Certification
Application for New Facility

Complete this application and submit to either address below. (Use supplemental sheets as necessary) Retain a copy of the application for your files.

U.S. Postal service address:
Department of State Health Services
Radiation Safety Licensing Branch
Mammography Certification Program
P.O. Box 149347, Mail Code (MC) 2835
Austin, Texas 78714-9347

Overnight/express service address
Department of State Health Services
Radiation Safety Licensing Branch
Mammography Certification Program
1100 West 49th Street
Austin, Texas 78756

Mammography Certification Program (512) 834-6688 - Fax (512) 834-6716

Section 1: General Information

Legal Name of Facility: _____
(Name should match that on Business Information Form RC 226-1)

Doing Business As (if applicable):_____
(Name should match that on Business Information Form RC 226-1)

County_____

Mailing Address: (Street/City/State/Zip) Machine Use Location Address: (Street/City/State/Zip)
(If multiple use locations, use additional sheets)

_____ _____

_____ _____

_____ _____

Facility Phone Number: _____ Fax No.: _____

Lead Interpreting Physician: _____

Radiation Safety Officer (RSO): _____
Attach qualifications as required in 25 TAC §289.226(t)(1)

Telephone No.: _____ E-mail address: _____

Contact Person & Title: _____

Telephone No.: _____ E-mail address: _____

Total number of machines on this application for certification:_____

Number of Mammography units: _____ Number of Stereotactic Biopsy units (stand-alone): _____

Number of Stereotactic Biopsy Attachments Used with a Mammography Unit_____

Section 2: Personnel

- List all mammography personnel.
  Review the "acceptable documents" forms for appropriate documentation. Submit required licenses/certifications, initial qualifications, continuing education and continuing experience documentation in accordance with §289.230(f).
- Make copies of this form as needed

Interpreting Physician(s):

_____

_____

_____

_____

_____

_____

_____

Radiologic Technologist(s)

_____

_____

_____

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Medical Physicist(s):

_____

_____

_____

Section 3: Equipment Information

Complete this section for each mammography x-ray unit.

Include a copy of a current medical physicist's survey report for each machine. (Note, if there are any failures and/or deficiencies on the report, attach a list of corrective actions and include copies of service/work invoices with the description of corrective actions. (The survey report must be dated within the past 6 months).

Machine Use Address:_____

Number of machines located at this site (address):_____

1. Control Panel Manufacturer: _____ Control Panel Model Name & Number: _____ Control Panel Serial Number _____
2. Type of Imaging System: ☐ Screen/Film ☐ Digital ☐ Digital Fuji CR
3. Is this unit used for a mobile operation? ☐ Yes ☐ No
4. Indicate the service for which this unit is used. ☐ Mammography ☐ Breast Biopsy*

*If using a Stereotactic Biopsy Attachment with a Mammography Unit and not a stand-alone biopsy unit, include the following information on the biopsy attachment:

Manufacturer _____ Model Number _____ Serial Number _____

Section 4: Accreditation Information

Accreditation Body: ☐ Texas ☐ American College of Radiology (ACR)

Section 5: Mobile Service Operation

Authorization from the Department is required prior to initiating mobile service operations.

Complete this section **only** if requesting authorization for mobile mammography service operations, [25 TAC §289.230(l)(8)]

Main location where machine and records. will be maintained for inspection. This must be a street address.

_____

Street City State Zip

Attach a sketch or description of the normal configuration of the mammography unit's use including the operator's position and any ancillary personnel's location during exposures. If a mobile van is used with a fixed unit inside, furnish the floor plan indicating protective shielding and the operator's location.

Submit a current copy of the mobile service operations Operating and Safety Procedures regarding radiological practices for protection of patients, operators, employees, and the general public.

Section 6-Self-referral Authorization

Self- referral is site based. All sites must have authorization from the Department prior to performing self-referred mammograms.

Complete this section **only** if requesting authorization to conduct self-referral mammography. [25 TAC §289.230(l)(8)]:

Number of views for a typical mammogram–_____

Type of views for a typical mammogram_____

ATTACH the following:

- the age range of the population to be examined and the frequency of the exam following established, nationally recognized criteria of the American Cancer Society, American College of Radiology, the National Council on Radiation Protection and Measurements;
- method of recommending means of selecting a physician to patients who do not have a physician,;
- written procedures for advising individuals and their private physicians of the results of the self-referred exam and any further medical needs indicated. Include a method of follow–up to confirm that patients with positive findings, as well as practitioners, have received proper notification;
- description of the methods used to educate patients in self-examination techniques, and on the necessity for follow-up by a physician; and
- film retention policy if different from the policy in Section 7.

Section 7: Medical Records Retention Policy

Submit procedures for disposition/retention of medical records, including films, in the event of termination, failure to renew, or bankruptcy.

Section 8: Signatures

I certify that all information submitted with this application is true and current to the best of my knowledge.

Typed or printed name of person completing the application	Date	Signature

Typed or printed name and title	Date	Signature

This shall be the signature of the Administrator, President, Chief Executive Officer, Owner or Partner of the facility.

I assume the responsibilities of **lead interpreting physician** as described in 25 TAC §289.230(k)(1)(A) for the facilities listed in this application.

Typed or printed name of lead interpreting physician	Date	Signature

I assume the responsibilities of **RSO** as described in 25 TAC §289.226(t)(2) for the facilities listed in this application. I certify that all information submitted with this application is true and current to the best of my knowledge.

Typed or printed name of RSO	Date	Signature

NOTE: Please include completed Business Information Form RC 226-1

PRIVACY NOTIFICATION: If you are applying as an individual, with few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.dshs.state.tx.us for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)